SEVG

SOUTHEAST VALLEY GASTRO

Thank you for selecting Southeast Valley Gastroenterology Consultants P.C. for your medical care.

Please be advised:

If your insurance requires you to have a referral or authorization for your office visit or procedure, it is ultimately **your responsibility** to obtain these before your appointment.

Our office will put forth as much effort as possible to help obtain these documents, but the **patient is ultimately responsible for any resulting costs** that may be associated with your visit or procedure.

Please call your insurance carrier so that you can better **understand your benefits**. Although our office does verify coverage, online services only provide limited information.

It is your responsibility to know which insurance is your primary carrier and which is your secondary. We rely on the information that the patient provides.

Our office **does not participate with AHCCCS insurance**. We will not accept any AHCCCS patients.

Many HMO's such as Aetna and Humana require authorization numbers for office visits and procedures. If we do not have the authorization at the time of this visit, your visit will be rescheduled.

THE PATIENT IS HELD ACCOUNTABLE FOR UNDERSTANDING THEIR BENEFITS, PROVIDING REFERRALS, OBTAINING AUTHORIZATIONS AND PAYING SUBSEQUENT OUT OF POCKET EXPENSES.

Thank you,

Southeast Valley Gastroenterology Consultants P.C.

Patients Signature: _____Date:_____

SEVG

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HIPAA CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature of Patient or Responsible Party: _____

Relationship to Patient: _____ Date: _____